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Health Financing In Ghana: Perceived Factors That Help Healthcare Facility Providers to Render Services to Clients of National Health Insurance Scheme

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Abstract

Health financing has become a universal concern especially for developing countries. Ghana has introduced National Health Insurance Scheme (NHIS) programme for its residents. This paper explores the perceived factors that help the accredited Healthcare Facility Providers (HFPs) to render services to the clients who have registered with the NHIS. The design used a survey which relied on questionnaire that provided six factors for respondents to rank according to how important they perceive the factor to help them in serving the clients of NHIS. These factors were selected based on the researcher's own interactions with the HFPs. Claims payment was ranked as the most important factor, followed by staff at post, patients support facilities, services rendered, culture at the facility and facility location. These factors were discussed and recommendations were made to help HFPs serve the clients of NHIS.

Keywords: National Health Insurance Scheme (NHIS), Healthcare Facility Providers (HFPs), Community-based Health Planning Service (CHPS)

1. Introduction

The economic development of countries thrives on the health conditions of their citizens. The quality of the health status of the citizens and other factors are the pivots that propel the economies from under development to industrialised ones. In view of this, governments all over the world prioritise the healthcare of their citizens and institute measures to make it accessible and affordable. Many countries therefore implement social interventions like health insurance to help alleviate the cost of financing healthcare of their citizens. Capon (1982) stresses that if health insurance is to strengthen preventive public healthcare systems, there would be value for money spent, reduction of disease burden and promotion of overall health system. Bailit, Newhouse, Brook, Duan, Collins, Hanley, Chisick & Goidberg (1986) on the contrary reveal that most countries fail in their health insurance policies because the health insurance policies only address the system of healthcare failure without reducing the disease burden which results from lack of preventive healthcare systems. This failure of preventive healthcare can escalate costs of curative medicine, which can eventually consume all the money for financing the healthcare.

In Ghana before 2004, the 'cash and carry' health financing made it compulsory for patients to pay cash for treatment in the clinics and hospitals. This system was not affordable to many people in Ghana. The 'cash and carry' system therefore presented a strong barrier to healthcare access to majority of Ghanaians (Agyepong & Nagai, 2011). The high cost of healthcare increased the financial burden of individuals and families. Therefore, an innovative and risk pooling mechanism to provide health security for the citizens became inevitable which necessitated the introduction of the National Health Insurance Scheme in Ghana backed by National Health Insurance Regulations Legislative Instrument 1890, 2004.

However, the cost of financing healthcare under the National Health Insurance Scheme (NHIS) has become burdensome because clients seem not to be satisfied with one healthcare facility provider so they visit many facility providers with the same sickness in a short period. This client healthcare facility provider shopping always throws the budget of the NHIS overboard because the various providers they visit must be paid claims for the duplication of consultation services they give and the repetition of same quantity of drugs they serve (NHIA, 2011). In view of this the main question of the study is: How can client multiple visits be resolved in order to improve the client healthcare facility provider loyalty in Ghana?

2. Overview of Ghana Health Financing

The healthcare system in Ghana was structured along the lines of its colonial master, Great Britain. In 1880, then Gold Coast under British colonial rule, Gold Coast Medical Department was set up and concentrated on providing healthcare for the European population, a few educated elites and government officials in particular (Akortsu & Abor, 2011). Dummett (1993) adds that, the era before independence, funding of healthcare was the sole prerogative of the colonial government or the missionaries where they were involved in the provision of healthcare at that time.

After independence, Ghana provided free healthcare services to its population through public health facilities. There were no out-of-pocket payments in these facilities and healthcare was financed solely from tax revenues. However, this was not sustainable in the light of the needs of other sectors of the economy, and the government had to find alternatives to this financing mechanism. The government at the time also embarked on massive development in infrastructure and human resource for health. As a result, by 1963, health centres in the country totalled 41 and health personnel totalled 3,169 and these included 379 doctors, 28 dentists, 954 midwives, 1,453 nurses and 355 pharmacists (Twumasi, 1975).

In the 1970s, nominal fees were introduced through legislations, but these proved insufficient to meet the needs of the health sector. The user fees were as a result of economic difficulties during the period (Twumasi, 1975). Between the 1970s and early 1980s, the global oil crisis from the sudden hike in oil prices on the international market severely affected the country. This immediately resulted in balance of payment difficulties, heavy debt burden and general economic disequilibrium. As a result, the World Bank and the International Monetary Fund (IMF) proposed structural changes to improving the economy, which suggested withdrawal of state subsidies. This led to declines in the health budget, putting the health sector under severe economic pressure (World Bank, 1993).

In 1985, the government at the time introduced a cost recovery programme known as the “user-fees system”. Laws enabling the charging of fees date back to 1969 with the introduction of the Hospital Fees Decree, 1969; National Liberation Council Decree (NLCD) 360; Hospital Fee Decree, 1969 (Amendment) Act, then, the 1970 (Act 325); then again the Hospital Fees Act, 1971 (Act 387). Smithson, Asamoah-Baah & Mills, (1997) suggest that these charges were however token fees charged compared to the 1985 legislation which raised the fees above token levels. There were however, exemptions for antenatal, family planning and communicable diseases (Nanda, 2002). These exemptions were, however, not taken useful because there were no guidelines for implementation and consumers were unaware of the existence of the exemptions. Compliance level by health staff was also poor (MoH, 2004).

In 1992, the government, in conformity with the Bamako Initiative of 1988 introduced the Revolving Drug Fund, which officially introduced the Full Cost Recovery Policy for drugs as a way of generating revenue to address the shortage of drugs. It was envisaged that the cost recovery process would contribute about 15 percent of the health sector resources. A review of the process in the First Five Year Programme of Work (1997-2001) of the Ministry of Health revealed that the contribution of the cost recovery process to the country's health sector financing was below 10 percent. The application of the revolving drug fund policy was popularly termed ‘cash and carry’ system. The ‘cash and carry’ system caused a decline in the utilization of healthcare services especially for the poor, who needed the services most, since this represented a financial barrier to access healthcare (Arhin-Tenkorang, 2000).

In order to improve access to healthcare services, a Law (Act 650; Republic of Ghana, 2003) establishing a national health insurance scheme was enacted in October 2003 known as the National Health Insurance Scheme (NHIS). This is with the ultimate vision of assuring equitable and universal access to healthcare for all residents of Ghana (MoH, 2004). The health insurance scheme is expected to provide funding for healthcare facilities. The provision of such funds is expected to aid in planning and also to reduce the incidence of bad debt or charitable services which tend to increase the expenditure pattern of healthcare facilities. The funding mechanism includes premiums paid by members to the insurance scheme they are registered with. Currently, 2.5 percent of all commercial invoices under the value added tax domain and pension contributions are paid into the health insurance fund. In year 2006, the health insurance fund represented about 31.6 percent of the total resource envelope of the health sector and in 2008, this accounted for 32.6 percent of total health sector financing (MoH, 2006,2008).

3. Methodology

3.1 Research Design

The design used for the study was a survey which employed questionnaire to collect data for the analysis. The study was to find out the perceived factors that help HFPs to serve the clients of NHIS who visit their place for treatment and other services in order to reduce the multiplicity of client HFP shopping.

3.2 Population and Sampling

The population for the study was accredited facility providers like clinics, polyclinics, district hospitals, regional hospitals, teaching hospitals, pharmacy shops, health centres, community based health planning services (CHPS) zones, Christian Health Service facility providers and private healthcare providers who serve the clients of NHIS in Ghana. Politically, Ghana has been divided into 10 administrative regions so each region was taken as a stratum in which a random sampling technique was used to select elements for the study. A sample size of 50 each was taken from seven regions that do not have teaching hospitals and 60 from the remaining three regions that have teaching hospitals. Altogether, a sample size of 530 healthcare facility providers was selected for the study.

3.3 Instruments and Data Collection

Questionnaire was used for the study. The questionnaire items were based on six factors which respondents were asked to rank according to how important they perceive the factor to help them to serve the clients of NHIS. These factors were selected based on the researcher's own interactions with the HFPs. Primary data was collected through the administration of questionnaire to healthcare provider personnel working in claims processing department, accounts department, district and regional health administration offices and pharmacy departments. Other personnel like medical superintendent officers, managers of pharmaceutical shops, heads of CHPS zones, heads of health centres and clinics also supplied primary data for the study. In all 530 questionnaires were distributed of which 450 were returned (Table 1), representing 85% response rate.

Table 1: Distribution of questionnaires and their return

Region	No. of questionnaires sent	No. of questionnaires received	Response rate in percentage (%)
Ashanti	60	54	90
Brong Ahafo	50	45	90
Central	50	39	78
Eastern	50	42	84
Greater Accra	60	51	85
Northern	60	48	80
Upper East	50	43	86
Upper West	50	41	82
Volta	50	42	84
Western	50	45	90
Total	530	450	85

4. Results and Discussions

The findings of the study on how the HFPs ranked the factors have been provided below in Table 2. This Table provides the factors, the number of respondents and percentages of their responses.

Table 2: Ranking of perceived factors by importance to HFPs

Factors	Number of respondents	Percentage (%)
Claims payment	171	38.0
Staff at post	117	26.0
Patients support facilities	54	12.0
Services rendered	45	10.0
Culture at the facility	43	9.5
Facility location	20	4.5
Total	450	100

4.1 Claims Payment

From Table 2, majority (38%) of the respondents consider the claims payment most important factor that helps them to render services to the clients of NHIS. The respondents indicated that in Ghana, they pre-finance the healthcare of the clients of NHIS. At the end of every month they send claims bill for payment. According to the National Insurance Law, Act 650 (2003), when claims bill is received at the insurance office, the vetting, investigating and payment processes should not exceed one month. The longer the NHIS office delays the payment, the more difficult the HFPs have on their cash and liquidity balances in their operations. When it delays it leads to a fall in the drugs and consumables in the stores, inability to pay salaries and allowances on time, inability to retain more qualified personnel, referral of common and basic drugs to pharmaceutical shops for service. If the claims payment delays beyond three months after submission, some HFPs especially the private owned ones discriminate against the clients of NHIS by refusing to attend to a large number of them but focus more on patients who do not use the NHIS cards when they attend hospitals because such patients would make immediate payment for their treatment. When claims are paid earlier and on time the HFPs have funds to replenish the drugs and consumables and also to hire and pay salaries and allowances of employees.

4.2 Staff at Post

From Table 2, a total of 26% of respondents ranked staff at post as important factor because according to them, health delivery is service and without the staff no healthcare can be given to any patient. These are people who have administratively, medically or clinically undergone training in recognised institutions and are working at the facilities. Where a facility provider has inadequate staff at post, there will be pressure on the few employed ones so they would not be able to serve well when more people visit their facility for treatment and other services. Due to this, some clients may not receive good attention from them especially those who come late to the facility after the workers have become tired. If the number of staff is adequate and well trained they can serve many patients anytime so clients may not spend too much time when they visit the facility for treatment. According to the National Health Insurance Regulations, LI 1890 (2004), HFPs are to renew their accreditation every two years and before renewal is done a team from National Health Insurance Authority's accreditation board must conduct thorough inspection with respect to the buildings, equipment and gadgets, qualification and adequacy of staff at post among others. Those who fail to meet the criteria are denied the accreditation and a ban is put on them from serving the clients of NHIS.

4.3 Patient Support Facilities

From Table 2, 12% of the respondents ranked patient support facilities as important because they are the elements of the quality of service that the HFPs render to their patients. These are the facilities that provide comfort to the patients when they are at the premises of the HFPs. These are the availability of clean environment which is free from mosquitoes breeding, comfortable and adequate chairs for out-patients, security, large compound where patients can park their cars, sufficient beds with mosquito nets for in patients, electricity or a generator plant in case there is power failure, continuous flow of water and good toilet facilities. When a HFP has good patient support facilities, it minimises the rate at which people attend hospitals with one ailment but leave there contracting other diseases. These patient support facilities are provided to make the patients feel comfortable and protected at the premises of the HFP. Manning, Bailit, Benjamin & Newhouse (1985) suggested that as claims payments are for drugs used and services rendered, HFPs should use part of the services income to do minor repairs and expansion in order to provide comfort for their patients.

4.4 Services Rendered

From Table 2, 10% of the respondents ranked services rendered by the HFP as important factor. The nature of some diseases demands that when patients attend a hospital or polyclinic, they need to undergo laboratory test, scan test, take x-ray photograph or see a specialist. If clients of NHIS attend a HFP and is referred to other HFPs for services like laboratory test and then come back for treatment, they may hesitate to go to such HFPs but would prefer to go to HFPs where they can get all the perceived benefits at one place. Most patients do not want to waste time in joining long queues at one HFP when it is their turn to be served only to be referred at the consultation room to go to a different HFP for laboratory test and return and join the queue again. If a particular HFP renders several services, they are able to serve the clients of NHIS within short time at one place.

4.5 Culture at the Facility

From Table 2, 9.5% of the respondents considered culture at the facility as important because HFPs are many so they need to devise strategies to be attractive to the patients so that when they come for treatment once they should always come again. Some HFPs have trained their staff very well in the way they should receive their patients, talk to and treat them. Some HFPs have the perception that if they treat their patients with good care and respect they will come there again the next time they fall sick so the HFPs will continue to depend on their patronage for survival in the business. The culture at the HFP's place is the brand that patients use to discriminate among the HFPs. Where patients are well respected and better served by the staff at the facility, they like attending that facility for treatment. To maintain the patients for a longer duration go beyond the mere treatment they receive at the clinics and hospitals. How to talk, treat, respect and serve the patients are some of the ingredients that cause the patients to stay on with the HFP.

4.6 Facility Location

From Table 2, 4.5% of the respondents consider the facility location as important factor because when a patient is in critical condition and needs to see a doctor at the hospital for immediate attention and can easily get there without any impediment of traffic jam or means of transport, then the facility location as a perceived factor helps the HFP to serve the patients. This is where the premises of the healthcare facility provider are situated. If the place is easily accessible, in terms of availability of good road networks, near proximity to the residence of the patient, availability of means of transport that ply the area, less vehicular traffic in the area of the location, a lot of patients visit that facility because they perceive that they would not waste much time before getting to the facility for treatment. On the other hand, when the hospital is not easily accessible and the patient is in critical condition, the delay on the way can cause any bad thing to happen to the patient.

5. Conclusion and Recommendations

The study focussed on the perceived factors that help the HFPs to render services to clients of NHIS. The findings revealed that among the factors, claims payment is an income generating factor which must be paid on time by the NHIS to relieve the HFPs from financial difficulties in order to serve the clients better. Also, HFPs which have a small number of staff at post delay the clients at their premises for a longer period before they are able to attend to them. HFPs which are located at easily accessible places mostly attract patients. The HFPs which have several departments like paediatric, maternity, laboratory, scan test and others serve all the clients at their premises without referring them to other places before coming there again to continue with their treatment. The HFPs which have good patient care are able to have longer good relationship with their clients. This obviously reduces client HFP shopping. From the above, some of the factors that emanate from the HFPs' domain (internal factors) like the services rendered and patient support facilities should be managed very well by HFPs themselves in order to render good services to the clients of NHIS. The external factor like claims payment is outside the control of the HFPs so the NHIS offices should not delay in vetting and paying the claims. According to the National Insurance Regulations LI 1890 (2004) NHIS offices which receive the claims can make at least half payment of the face value of amount submitted immediately the claims arrive at their office and take at most a month to do the vetting before they can pay the remaining balance. When HFPs are able to serve the clients very well it will lead to clients' loyalty which will minimise the clients multiple visits to different providers.

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